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TRANSCRIPT OF VIDEO RECORDING OF

SENATE PUBLIC SAFETY COMMITTEE

SENATE HEARING ON COVID-19 IN CALIFORNIA STATE PRISONS

JULY 1, 2020

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JULY 1, 2020

CHAIR SKINNER: All right. The Senate Committee on Public Safety will come to order. Good morning. In response to the COVID-19 emergency, and to protect our public, the Senators, and Senate staff, we are limiting nonessential gatherings, and adhering to social distancing. In compliance with these orders, the Senate will be holding an essential hearing, and has made necessary adjustments to normal practices in order to ensure that the public continues to have access to the legislative process, while we conduct the hearing in a way that protects the health and safety of the public, and our employees.

To allow for public access, we have admitted members of the public to the balcony, and to a hearing room, to the extent that social distancing requirements allow, and we will also be using a teleconference service for those individuals who wish to testify today. If you wish to provide public comment at the end of the hearing, there is a participant toll free number, and access code. It is posted on our Senate Public Safety Committee website, but I will announce it to you now.

It is 844-291-6364, participant code 7365485. When we move to public comment, a moderator will identify you individually, open your line, and at that time, you may address the Committee.

Please note that in order for us to hear you clearly, you must mute the device you are watching the hearing on, prior to giving your testimony over the phone. Thank you for your patience.

While every effort has been made to streamline the hearing process, and conduct our informational hearings a close to the same manner as is customary, there may be lag times for some participants adjusting to the use of the new online tools or technologies, and you never know when there can be just technological difficulties. Please be respectful and patient, so that all interested parties can be heard.

So we will now begin the Bill Hearing. I want to thank everyone for participating. In addition to our committee members, we welcome Senator McGuire, and on the Zoom will be Assembly Members Levine, and Assembly Member Kalra.

Let me open with some comments, and then I will ask if Senator Moorlach or Senator Bradford would like to make any opening comments, which I hope can be brief, and then we will turn to Senator McGuire and Senator -

primarily in the skilled nursing facilities, and prisons. And we are here to partner, and we continue to have dedicated staff to this effort, and are happy to not only play the role of technical consultants, but to be part of the - these Incident Management Teams.

CHAIR SKINNER: Thank you, Ms. --

SUSAN FANELLI: So I'll stop and --

CHAIR SKINNER: Thank you, Ms. Fanelli.

SUSAN FANELLI: (unintelligible)

CHAIR SKINNER: I will note that the visitation stopped, CDCR ended visitation at all facilities before April 1st. Additionally, many of the things you described were, at least by the Department's own indications, implemented; and yet - many were not - but yet we have the situation we have today, so, how thoroughly these were implemented. But I would say that the movement of - the Administration themselves stopped the transfer from county jails. The visitation was stopped. All of those things were done. Anyway - let's now turn to Clark Kelso, who is the Federal Receiver for the - our state prison system, California Correctional Healthcare Services. Mr. Kelso.

RECEIVER KELSO: Hi. Good morning, Madam Chair, and members. My name is Clark Kelso. I serve as the Federal Receiver responsible for medical care within

CDCR. I was appointed to this position by the federal court in the class action litigation, Plata versus Schwarzenegger in 2008, and was charged with bringing the level of medical care up to Constitutional standards. As Receiver, I exercise all of the powers that Secretary Diaz possesses, but with respect only to the Department's medical care system. That's why both Secretary Diaz and I are here today.

A significant amount of progress has been made in improving CDCR's overall healthcare system, which has contributed to our capacity to respond to the COVID risk. And I have delegated back to the State, Madam Chair, as you noted, the management of 19 of its 35 institutions, which is a presumptive indicator that those institutions are delivering a Constitutional level of care.

COVID, of course, is a new and systemwide challenge. And so I work most closely with Secretary Diaz, and Undersecretary for Healthcare, Diana Toche, on COVID matters. Faced with the crisis of COVID, our collaboration has never been closer.

I'd like to give you an overview of our planning and efforts to combat COVID-19 over the last four months, some comments on the crisis at San Quentin, and a brief status report; and then of course, take

questions.

Planning, as you've heard, began in late February. As you know, CDCR essentially operates the largest congregate living facilities in the state, which are perfect facilities for the spread of communicable diseases. So on March 11, CDCR's Public Health Branch issued its first COVID guidance to the institutions, based in part, and including links to, guidance published by the Centers for Disease Control, California Department of Public Health, and the California Occupational Safety and Health Administration, and we began posting that guidance on our intranet pages.

We also released our public-facing internet sites that contain the COVID tracker for the prisons, CDCR's COVID preparedness pages, and Healthcare's interim guidance. The interim guidance is particularly important for our institutions, because it has the basics to combat an outbreak, including directions on testing, isolation, contact tracing, quarantine, monitoring, hospital referrals - everything that Dr. Ghaly has mentioned.

Two days later, on March 13, Secretary Diaz and I sent out our first communication to all CDCR employees to begin reorienting everyone to the challenges that were to come. And our first case occurred only one week

later, on March 20th, at CIM, the California Institution for Men. Now, during March and April, as you have heard, CDCR took a series of important steps, including establishing an overall COVID-19 Coordinator, standing up the Department's Operations Center, sending out guidance for facility entrance screening for all staff, implementing an accelerated release program, imposing severe restrictions on intra-facility movement, shutting down visitations, halting all nonessential transfers between prisons, and closing CDCR to intake.

The number of cases at CIM grew slowly during April, but cases spiked on May 1st, jumping from 91 to 218. And the number of cases continued climbing, reaching a high of 475 by May 15th. As a result, during the first three weeks of May, we considered whether we could safely move a large number of those vulnerable patients, the negatives, to another facility - with the goal of saving lives. The decision involved a balancing of the growing risks to the CIM patients against the risks of any large scale transfer.

We were also considering in May how the Department could slowly begin reopening and reestablishing some of its normal processes. And on May 22, a memorandum was distributed to the field, announcing CDCR's phased approach, which included a slow

reopening of intake, and the resumption of inter-institution movement.

Attached to that memorandum was a COVID screening and testing matrix for patient movement. The - the matrix provided, among other things, that a transferring patient should receive a COVID test; that a patient could transfer only if the test was negative; and that no individual should be transferred to another institution prior to the availability of their test results.

On or about May 23rd, we decided that the expanding cases at CIM posed an unacceptable risk to the last remaining dorm, where hundreds of COVID high risk patients were housed, and the decision was taken to move those patients out of CIM. Some were moved to Corcoran, and the remainder were moved to San Quentin.

Because the matrix did not specify that the required negative test had to occur within only a short period of time in relation to the transfer, such as seven days or less, when the moves were made out of CIM, although all patients had negative test results, in many cases, the tests were two, three, and in some cases, four weeks old - far too old to be a reliable indicator for the absence of COVID. As it turned out, two of the 66 patients moved to Corcoran tested positive when they

were retested at Corcoran. The rest were negative. Corcoran has been managing their outbreak pretty well so far. They have 125 cases active, 30 cases have already resolved, and they have had 47 of the 125 cases in the last 14 days. They've sent out to the hospital only one patient.

San Quentin, of course, has been a very different story, and is in crisis. Upon retesting at San Quentin, 25 out of 122 transferees tested positive, and San Quentin almost immediately fell behind the virus. On June 12, I asked Dr. Brie Williams from the University of California at San Francisco, and Dr. (unintelligible) Pretrosi (phonetic) from the UC Berkeley School of Public Health, to conduct an in person assessment. They visited the prison the next day, on June 13, and reported serious resource deficiencies in the physical plant, in COVID support staffing, and in testing.

The following deficiencies, most of which were identified in their report, materially contributed to the rapid spread of covid at San Quentin. First, the five-tiered cell blocks lack good ventilation, and they have virus spread characteristics, similar to a dormitory setting, even though inmates are housed in cells in those cell blocks. The virus spread very

rapidly in those conditions.

Second, we had testing turnaround time problems. Now, we did not have this problem at other institutions, where we successfully contained the virus. But we have this problem at San Quentin. Our vendor has agreed to put our tests at a higher priority within their testing system, and we are working with the Biohub in San Francisco to perform some of our tests. We have completed the first round of testing of all patients at San Quentin who've consented to be tested.

Third, many patients at San Quentin refused being tested, or even being assessed for symptoms. So for example, between two and three hundred patients in the East Block are refusing tests and assessments, and that makes it difficult to manage the outbreak. Yesterday, the Prison Law Office offered to assist us in working with their clients on this issue - an offer we, of course, have accepted, and I'm grateful to the Prison Law Office for their help in this regard.

Fourth and finally, the physical layout at San Quentin makes it difficult to manage the population during an outbreak. It has been difficult to separate patients appropriately, and the institution needs additional bed space. We had hoped last week that one way of increasing the available space was to move 100

inmates from the San Quentin gymnasium, to an empty wing of housing at North Kern State Prison. To ensure the safety of that transport, we had adopted a much stricter transport testing policy, so that all 100 patients had to receive a negative COVID test no more than 48 hours prior to the transport. On Saturday, we learned that two of those patients have received positive test results, and we cancelled the entire move.

As of this morning, San Quentin reports 1127 active cases, with 809 of those occurring in the last 14 days. We have had one death of a patient who tested positive for COVID-19. We've had 42 hospital admissions out of San Quentin. I believe during the week of July 6, it is likely that we should be seeing a significant number of the positive cases at San Quentin, perhaps as many as 300, move from active to resolved status, since we know that we have at least that many positives who are still asymptomatic.

Our two biggest concerns now are insufficient resources at San Quentin to handle the enormity of the crisis, and the capacity of local hospitals to deal with the flow of San Quentin patients. The Administration is responding to the resources problem by directing Cal OES to establish a unified Incident Command to help manage the outbreak. That began yesterday, I believe.

And we are redirecting an Associate Director from the Division of Adult Institutions, and a regional healthcare executive to support institution staff, and the Incident Commander. This will help stabilize response to the outbreak. The State has also flown in tents for additional clinic and housing space, and Cal OES will be bringing in a field hospital to provide more beds, and housing.

With respect to local hospital capacity, we are in frequent, ongoing contact with Bay area hospitals. And at this point, we are confident the necessary capacity exists. For example, Seton Medical Center in Daly City is making itself ready to - to accept a substantial number of our patients, and we have other arrangements in place with other hospitals. We do monitor this on a daily basis, because we know that hospital utilization can change rapidly during the pandemic.

We also appreciate that Marin General Hospital, San Quentin's primary local hospital, does not itself have sufficient resources for our likely needs. And they and the community are understandably concerned about their ability, even in their Emergency Department, to stabilize patients before transfer to other hospitals. We'll continue working with Marin General.

And if it appears that Marin General cannot handle the flow, arrangements will be made to transport patients directly to other hospitals, so as not to overwhelm Marin General's resources. We are sensitive to their concerns.

Let me close with a brief status report. Systemwide, we have 2600 active cases, 2200 cases that have resolved, and 22 deaths. That gives us an overall death rate of 0.44%. While acknowledging the statistical challenges of different population sizes and confounders, CDCR's crude death rate of 0.44% is a magnitude of order less than the state of California's COVID death rate, which is 2.7%, and the United States' overall COVID death rate, which is 4.9%. Don't put too much reliance on that comparison until we've had an opportunity for the California Department of Public Health to perform a, a more granular, better analysis of the comparison to make sure that we're not comparing apples to oranges.

We have had very large outbreaks in four prisons - San Quentin with 1113 positives; Chuckawalla, with 1012 positives; Avenal, 938 positives; and CIM, 896 positives. The outbreaks at Chuckawalla and Avenal have mostly resolved. CIM and San Quentin - CIM has not resolved; San Quentin, we're at the beginning of.

Next, we successfully managed a moderate outbreak at California Institution for Women, which had at one time 168 total cases, but which now has only six cases, and only one of those was in the last 14 days. CIW experienced one death. A second prison, Lancaster, also had a moderate outbreak with 128 positives, all of whom have now resolved, with zero cases in the last 14 days. We have another four prisons with moderate outbreaks that so far appear to have peaked, with around 200 or fewer total cases. Finally, we have 14 institutions that have experienced small outbreaks that have not blossomed into moderate or large events, and 11 facilities with no COVID cases among inmates currently identified.

These are significant achievements, given COVID's ease of entering and spreading in congregate housing settings. These numbers, I think, do indicate that COVID has not spread yet throughout the CDCR system in an uncontrolled fashion. But given that COVID is going to be with us for quite some time, I share everyone's concern that what we have done to date still is not enough. There is more that can be done, because the virus has plenty of time to continue spreading throughout the system.

Right now, and until things stabilize further

systemwide, Secretary Diaz has closed intake again, stopped all unnecessary movement between institutions, reimposed a systemwide modified program, and adopted a new and continued accelerated release program. And I know that he shares my view that we will not open intake, or start movement again until we have assured ourselves, and others are assured, that it can be done safely. Thank you, members for your attention. I'll be happy to take questions, along with the rest of the panel.

CHAIR SKINNER: Thank you, Mr. Kelso. So members, we've now heard from the panelists for the first panel. So I will open it to questions. I would first, though, like to ask - and this can be Secretary Diaz or Mr. Kelso - while there was indication that, you know, there is now limited numbers, I just want to be clear that by CDCR's own statistics posted on your website, there have been incarcerated individuals who have tested positive at 24 out of 35 facilities. That's on your own website. Now, I would suspect there could be far more than that, only because it is my understanding, and it seems to have been confirmed by all the panelists thus far, that not every inmate is tested. So since there is not thorough testing, we can't know.

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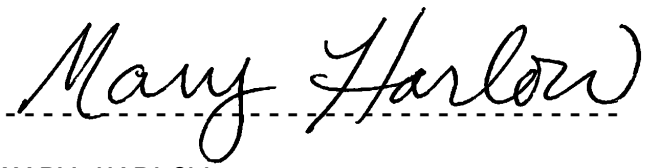

MARY HARLOW